Exhibit 13

INSIGHT IMAGING

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Home > Center Locations > Virginia > Insight Imaging - Roanoke

Virginia

- Insight Imaging - Arlington
- Insight Imaging - Fairfax
- Insight Imaging - Roanoke
- Insight Imaging - Woodbridge

Insight Imaging - Roanoke

Insight Imaging - Roanoke is a comprehensive, freestanding diagnostic imaging center. We provide high-field MRI, open MRI, CT, ultrasound, digital X-ray, fluoroscopy and pain management (Image-Guided Theraputics) services. For patients and physicians we deliver quality diagnostic imaging that's convenient, simple and affordable. Our unique approach is Patients First care. From online services and friendly staff, to superior diagnostic image quality and accurate reports, the Patients First way of life is the reason patients choose our imaging center – we hope you will choose us too.

With advanced imaging technology operated by our qualified and caring professionals, we are confident that your visit with us will be a pleasant experience. Our expert, licensed technologists and board certified and sub-specialty radiologists deliver the highest quality results to ensure diagnostic accuracy.

By providing superior imaging service in a caring and compassionate manner, we are committed to making the imaging process simple and trouble free. We hope to earn your trust and become the provider of choice for all your diagnostic imaging needs. If there is anything we can do to improve your visit, don't hesitate to let us know.

Patient Feedback

The staff was very friendly and seemed to care about my condition. They made me feel very comfortable during the CT scan and asked me if I was okay several times. When I was preparing to leave, they shook my hand and wished me well. I actually felt like they were my friends! – Insight Imaging Roanoke Patient, November 2012

I rated all questions excellent on the survey, not randomly, but because the rating was truly excellent. All the staff were very personable, kind and considerate--especially since I was late due to my shortcut causing me to be stopped by a train. The technologist was especially kind and helpful--doing everything possible to make me comfortable. All the paperwork processes were quick, considering it was paperwork. I had a very pleasant experience at Insight Imaging, and would not hesitate to return for another procedure and to recommend it to my friends! Please forward my comments to the staff. Thanks! – Insight Imaging Roanoke Patient, November 2012

Physician Resources

View Films

Exam Preparation

- Patient Registration
- Patient Authorization
- MRI Screening
- MRI Patient History
- CT Patient History
- Privacy Practices

ADDRESS

2923 Franklin Road S.W.
Roanoke, VA 24014
Phone: (540) 581-0882
Fax: (540) 581-0881

map/directions

email us

HOURS OF OPERATION

M-S: 8:00am - 5:00pm
Su: Closed

OUR SERVICES

High-field MRI, Open MRI, CT, Ultrasound, Digital X-Ray, Fluoroscopy, Pain Management - Image-Guided Therapeutics

INSIGHT IMAGING

Jacket Number_____

Patient Registration Form

Patient Information

Patient Name (Last) _____(First)_____ (MI)_____

Sex _____ Date of Birth ____/____/____ Weight _____ Height _____ Social Sec. No. _____

Address: _____City _____ State_____ Zip_____

Home Phone: (____) _____Marital Status: _____ Work Phone: (_____)_____Ext._____

Student Status (Check One): ☐ Not a Student ☐ Full Time Student ☐ Part Time Student

Employer Information

Employment Status (Check One): ☐ Employed Full Time ☐ Employed Part Time ☐ Self Employed
☐ Not Employed ☐ On Active Military Duty ☐ Retired

Employer Name_____

Address _____ City _____State _____Zip_____

Phone (_____)_____

Emergency Contact

Name (Last)_____ (First)_____

Home Phone (____)_____Work Phone (____)_____Ext. _____ Relationship _____

Address _____City_____ State_____ Zip_____

Primary Insurance Information

Group Number _____ID Number _____

Insurance Carrier _____Phone (____)_____

Claims Address (include PO box) _____City_____ State___ Zip_____

Insured's Name (Last)_____(First)_____(MI)_____

Insured's Address_____City_____State_____Zip_____

Insured's Birth Date ____/____/____ Social Sec. No._____ Phone (____)_____

Insured's Employer_____ Work Phone (___)_____Ext._____ Relationship _____

Employer Address_____City_____State_____Zip_____

COMPLETE OTHER SIDE FOR RESPONSIBLE PARTY, SECONDARY OR ACCIDENT INSURANCE INFORMATION

Revised 10/01/03

Responsible Party (who pays the non-covered medical bills for this patient?)

Guarantor: Name (Last)_____ (First)_____(MI)____

Home Telephone (____)_____ Work Phone Telephone (____)_____ Ext._____

Address _____City _____State_____ Zip _____

Social Sec. No. _____ Relationship to Patient: _____

Employer Name_____

Employer Address _____City_____ State_____ Zip_____

Secondary Insurance Information

Is this a Medicare supplement? _____

Group Number _____ID Number_____

Insurance Carrier_____ Phone (____)_____

Claims Address (include PO box)_____City _____State ____ Zip_____

Insured's Name (Last)_____(First)_____(MI)_____

Insured's Address_____City_____State_____Zip_____

Insured's Birth Date ____/____/____ Social Sec. No. _____ Phone (____)_____

Insured's Employer _____Work Phone (____)_____Ext. _____ Relationship_____

Employer Address_____City_____ State____ Zip_____

Work Related/Accident/Personal Injury Insurance

Check One: ☐ Employment ☐ Auto Accident ☐ Other Accident Injury Date: ___/___/___ State Where Injury Occurred: ____

Insurance Carrier_____ Phone (_____)_____

Claims Address (include PO box)_____City _____State _____ Zip_____

Claim Number _____Claims Adjuster _____ Phone (_____) _____

If applicable:

Name of Attorney _____ Phone (_____) _____ Ext. _____

Address of Attorney _____ City _____ State _____ Zip _____

I hereby certify that all information in this Patient Registration form is true and correct

_____ _____ _____

Patient or Legal Representative Signature | Print Name and Authority (if legal representative) | Date

INSIGHT IMAGING

Patient Authorization and Responsibility Form

Patient Name: _____ Patient Account Number: _____

I, the undersigned, in consideration of the provision of _____ (the "procedure') by INSIGHT IMAGING ("Center") hereby acknowledge and agree to the following terms and conditions:

Consent to Procedure: I hereby consent to and authorize the Center to perform the procedure in accordance with the general and special instructions of my treating physician or the physician supervising the procedure. I also acknowledge that my physician has fully explained to me the procedure and all risks, benefits and any alternative procedures.

Authorization/Assignment of Benefits: I hereby authorize and assign payment of any benefits due me under the terms of any insurance policy or policies that may cover the procedure performed on me or my dependent(s) by Center directly to Center at the address designated by Center on any claim form submitted to my insurance carrier. I agree that payment to Center pursuant to this authorization/assignment by my insurance company shall discharge said insurance company of any and all obligations under the policy to the extent of such payment. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment and I authorize Center to contact my employer for the purpose of determining the existence and extent of any insurance benefits. I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. Should my account become delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law. If Center undertakes collection efforts to recover any past due amounts, I agree to pay all reasonable costs incurred, including attorney's fees.

Responsibility for Valuables: I hereby understand and acknowledge that Center is not responsible for the loss of, damage to, or theft of any of my, or and my dependent's, personal possessions, including, but not limited to, money, jewelry, clothing or other valuables, while I or my dependents are on Center's premises.

Authorization/Consent to Release Information: I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, or utilization review representative to release to Center any and all information with respect to me or my dependent(s) which may have a bearing the treatment I or my dependent(s) receive at the Center or on any benefits payable by my insurance company for the procedure performed by Center on me or my dependent(s). I agree that this authorization shall remain effective for one (1) year from the date indicated below. I hereby authorize Center to release to my insurance company or to any physician or other healthcare provider providing treatment to me or my dependent(s) all information with respect to me or my dependent(s) which may be necessary for the provision of health care services to me or my dependents or regarding benefits payable to me or my dependent(s).

Notice of Privacy Practices: I acknowledge that I have been provided with a copy of the Center's Notice of Privacy Practices. I acknowledge that I have reviewed the Notice of Privacy Practices prior to signing this consent. I understand that Center reserves the right to change its Notice of Privacy Practices without notice to me.

For Medicare Patients Only - Authorization to Release Information and Payment Request: I hereby request that payment of authorized Medicare benefits be made on my behalf to Center for any services rendered by Center. I hereby authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurances and any other charges not covered by Medicare are my responsibility.

_____	_____	_____
Patient or Legal Representative Signature	Print Name and Authority (If legal representative)	Date

INSIGHT IMAGING

MRI Screening Questionnaire

Patient Name:_____ Date:_____

Sex:_____ DOB:_____ Weight:_____ Height:_____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. **If you don't understand any question, please ask for assistance.**

1. Do you have a cardiac pacemaker, implantable cardio defibrillator, stents, or cardiac wires? Yes ☐ No ☐ Don't Know ☐
2. Do you have cochlear implants in your inner ear? Yes ☐ No ☐ Don't Know ☐
3. Do you have a history of kidney disease or currently on kidney dialysis? Yes ☐ No ☐ Don't Know ☐
4. Have you ever had any head surgery requiring aneurysm clips? Yes ☐ No ☐ Don't Know ☐
5. Have you ever had any type of surgery? Yes ☐ No ☐ Don't Know ☐

   If yes, please list: _____
6. Do you have any surgically implanted metal of any type in your body? Yes ☐ No ☐ Don't Know ☐

   If yes, please list: _____
7. Do you have any metal pins, prosthesis or metallic object in, or attached to, your body? Yes ☐ No ☐ Don't Know ☐

   If yes, please list: _____
8. Have you ever been exposed to metal fragments that could be lodged in your eyes or body? Yes ☐ No ☐ Don't Know ☐
9. Do you have a hearing aid, middle/inner ear prosthesis or dentures? Yes ☐ No ☐ Don't Know ☐
10. Do you have any type of electronic device (stimulator or pump) implanted in your body? Yes ☐ No ☐ Don't Know ☐
11. Do you have or have you ever had tattoos, tattooed eyeliner, lipliner or body piercing? Yes ☐ No ☐ Don't Know ☐
12. Do you wear a medicine skin patch on your body (e.g., nitroglycerin, nicotine, or hormone)? Yes ☐ No ☐ Don't Know ☐
13. Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray? Yes ☐ No ☐ Don't Know ☐
14. Do you have a history of panic attacks or a fear of enclosed or narrow places? Yes ☐ No ☐ Don't Know ☐
15. If you are a woman – are you pregnant, or is it possible that you might be pregnant? Yes ☐ No ☐ Don't Know ☐
16. If you are a woman – are you breastfeeding? Yes ☐ No ☐
17. Is there any other item or device you believe we should know about prior to performing the procedure – if yes, please describe:

    _____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the Center of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Center from any and all liability for any injury.

Patient or Legal Representative Signature	Print Name and Authority (if legal representative)	Date
Witness or Interpreter Signature	Print Name	Date
Physician/Registered Nurse/Technologist	Print Name and Title	Date

Revised 07/15/07

INSIGHT IMAGING

Patient History Questionnaire (MRI)

Patient Account Number: _____

Patient Name: _____ Date: _____

Reason for Procedure:

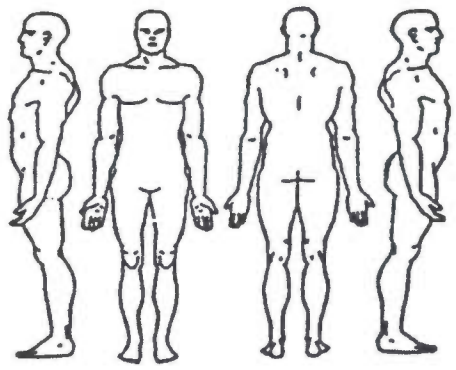
Please check any of the following symptoms that you are experiencing:

- ☐ Chest pain ☐ Headaches ☐ Nausea ☐ Hearing loss
- ☐ Abdominal pain ☐ Blackouts ☐ Blurred vision ☐ Ringing in ears
- ☐ Pelvic Pain ☐ Dizziness ☐ Memory loss ☐ Seizures
- ☐ Back pain ☐ Neck pain ☐ Unexpected weight loss
- ☐ Shoulder pain - (☐ Right/☐ Left) ☐ Numbness - (☐ Right side/☐ Left side)
- ☐ Leg pain - (☐ Right/☐ Left) ☐ Weakness - (☐ Right side/☐ Left side)
- ☐ Arm pain - (☐ Right/☐ Left) ☐ Other: _____

How and when did these symptoms occur (e.g., injury, just started, etc.)?

_____

_____



LEFT FRONT BACK RIGHT

Please identify the location of any pain/numbness/lump

Medical History:

1. Do you have or have you had any of the following?
   - ☐ Cancer ☐ Heart disease ☐ Kidney/renal disease ☐ Multiple myeloma ☐ Hypertension
   - ☐ Seizures ☐ Sickle cell anemia ☐ Tumor, lump or mass ☐ Bleeding tendency ☐ Heart arrhythmia
   - ☐ Diabetes ☐ Congenital heart defect ☐ Glaucoma ☐ Stroke
   - ☐ Asthma, bronchitis or emphysema ☐ Other illness/disease: _____
2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing? ☐ Yes ☐ No
   If yes, please list the date, type and who performed the test: _____
   _____
3. **Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.)? ☐ Yes ☐ No**
   If yes, please list the date and type of surgery or therapy: _____
   _____
4. Are you currently taking any medications? ☐ Yes ☐ No
   If yes, please list all medications you are currently taking: _____
   _____
5. Do you have any allergies (e.g., medications, latex, food, etc). ☐ Yes ☐ No
   If yes, please list all allergies: _____
   _____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Patient or Legal Representative Signature | Print Name and Authority (if legal representative) | Date

Technologist Notes: _____

_____

_____

Revised 02/20/2009

INSIGHT IMAGING

Patient History Questionnaire (CT)

Patient Account Number: _____

Patient Name: _____ Date: _____

Date of Birth: _____ Weight: _____

Please describe your symptoms that necessitated a CT Scan:

_____

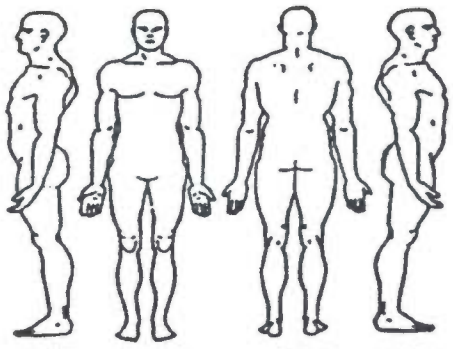
_____

_____

How and when did these symptoms occur (e.g., injury, just started, etc.)?

_____

_____



LEFT FRONT BACK RIGHT

Please identify the location of any pain, Numbness, or lumps

Medical History:

1. Do you have or have you had any of the following:

☐ Cancer	☐ Heart disease	☐ Kidney/renal disease	☐ Multiple myeloma	☐ Hypertension
☐ Seizures	☐ Sickle cell anemia	☐ Tumor, lump or mass	☐ Bleeding tendency	☐ Heart arrhythmia
☐ Diabetes	☐ Congenital heart defect	☐ Chemotherapy	☐ Stroke	☐ History of smoking
☐ Glaucoma	☐ Radiation Therapy	☐ Asthma, bronchitis or emphysema		

☐ Other illness or disease: _____

2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing? ☐ Yes ☐ No
   If yes, please list the date and type of test and where test was performed: _____
   _____

3. **Have you had any surgeries? ☐ Yes ☐ No If yes, please identify the area of your body where the surgery was preformed:**
   ☐ Brain ☐ Heart ☐ Colon/Intestine ☐ Hysterectomy ☐ Rectum ☐ Breast ☐ Liver ☐ Ovaries
   ☐ Spleen ☐ Appendix ☐ Gallbladder ☐ Thyroid ☐ Prostate
   ☐ Other: _____

4. Do you have or have you had any food or drug allergies (e.g., Benadryl, prior X-Ray contrast agent reaction, etc.)? ☐ Yes ☐ No
   If yes, please list each food or drug allergy: _____
   _____

5. Are you currently taking any medications (e.g. Glucophage (METFORMIN), Glucovance (GYLBURIDE), etc.)? ☐ Yes ☐ No
   If yes, please list all medications you are currently taking: _____
   _____

Females Only:

6. Are you, or is it possible that you might be pregnant? ☐ Yes ☐ No ☐ Don't Know Are you breastfeeding? ☐ Yes ☐ No
   First day of last menstrual period ("LMP"): _____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Patient or Legal Representative Signature | Print Name and Authority (if legal representative) | Date

Technologist Notes: _____

_____

_____

Revised 02/20/2009

Effective Date: April 14, 2003 [updated December, 2010]

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. – PLEASE REVIEW IT CAREFULLY –

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you in accordance with all federal and state laws. When you receive services at the Center we create a record and need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to the Center's records that are generated by your visit to our Center, whether these records are made by the Center or your personal doctor.

WHO WILL FOLLOW THESE PRIVACY PRACTICES:

This notice describes the practices of this center (the "Center") and that of any health care professional who is authorized to practice at the Center and to enter information into your medical record at the Center. All Center employees, staff and other personnel at the Center have agreed to follow the terms of this notice. In addition, these entities, sites and individuals may share medical information with each other for the treatment, payment or Center operations purposes described in this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures we will explain what we mean and may give some examples. While not every use or disclosure in a category is listed, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment/services. We may disclose medical information about you to doctors, nurses, technicians, or other Center personnel who are involved in your care at the Center. For example, a radiologist may need to know your health history to determine whether or not you are an appropriate candidate for contrast media. To assist with your care outside the Center, we may disclose your medical information to your doctor or other health care providers. For example, we may provide your medical information to a doctor who is seeing you in his or her office.

- **For Payment**. We may use and disclose medical information about you so that the treatment/services you receive may be billed to and payment collected from you, your insurance company or a third party. For example, we may need to give your health plan information about an imaging procedure you received at the Center so your health plan will pay us or reimburse you for the procedure.

- **For Health Care Operations**. We may use and disclose medical information about you for Center operations or for operations related to organized health care arrangements with radiologists who treat you at the Center. These uses and disclosures are necessary to run the Center. For example, we may use medical information to review our services and to evaluate the performance of our staff in caring for you.

- **Health Information Exchange.** We may use and disclose and disclose medical information about you to facilitate a "Health Information Exchange". Health Information Exchange is the sharing of healthcare information electronically among doctors, hospitals, and other healthcare providers within a region or community. Basic identifying and medical information may be shared with other health care providers that are treating you through a health information exchange.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment/services at the Center.

- **Procedure Alternatives or Health Related Benefits or Services**. We may use and disclose medical information to tell you or your physician about or recommend possible treatment options or alternatives that may be of interest to you or more appropriate. We may also use and disclose medical information to tell you about health-related benefits or services that may be of interest.

- **Business Associates**. We may disclose medical information to those that we contract with as business associates so that they may do their jobs on behalf of the Center. Examples include management services, transcription services and translator services. We require that all business associates implement appropriate safeguards to protect your medical information.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. Except in certain limited situations, such as an emergency or if you are unable to communicate, we first will give you the opportunity to agree or object to this disclosure.

- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is likely to help prevent the threat.

SPECIAL SITUATIONS:

- **Military Personnel**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**. We may release medical information about you to the extent required by law for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Activities**. We may disclose medical information about you as authorized by law for public health activities. These activities generally include the following:

  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to report workplace illness or injury; or
  - to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

• **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

• **Lawsuits and Disputes**. If you are involved in a lawsuit, a dispute, or some other legal action, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the requesting party states that it has made efforts to tell you about the request or to obtain an order protecting the information requested.

• **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:

- where required by federal, state, or local law;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person (but we will only give limited information);
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about criminal conduct at the Center; and
- in emergency circumstances to report: a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

• **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner as necessary, or required, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

• **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

OTHER USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you permit us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding medical information we maintain about you:

• **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information we put together to prepare for a legal action, and certain information covered by laws relating to laboratories. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Center. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may be able to request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. In certain limited situations, we will have to deny you access but will not be able to give you a review.

• **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Center. To request an amendment, your request must be made in writing and submitted to the Center. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for the Center;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for an amendment, we will notify you of the reason for the denial. If you disagree with our denial, you may submit a statement of disagreement or ask that your request become part of your record. In response, we may prepare a rebuttal statement. These will be made a part of your record.

• **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of most of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Center. Your request must state a time period which may not be longer than six years and may not include dates before 2004. Your request should indicate in what form you want the list (e.g., on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. To request restrictions, you must make your request in writing to the Center. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we inform you that we will no longer comply with your request.

• **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Center. We will not ask you the reason for your request. We will accommodate reasonable requests. Your request must specify how or where you wish to be contacted. Agreements for confidential communications are conditioned upon obtaining information about how payment, if any, will be handled. We may terminate our agreement for confidential communications if payment arrangements are not honored.

• **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice and may keep this brochure. You may ask us to give you a copy of this notice at any time.

OUR RESPONSIBILITIES REGARDING YOUR MEDICAL INFORMATION: We are required by law to (1) keep medical information that identifies you private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the changed notice effective for medical information we already have about you as well

as any information we receive in the future. We will post a copy of the current notice in the Center. The notice will contain on the first page, in the top left-hand corner, the effective date.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Center by contacting our Privacy Officer at 1-877-TIIP-OFF. In addition, you may file a complaint with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

If you have any questions about this notice, please contact the Privacy Officer at (877) TIIP-OFF or by e-mail to PrivacyOfficer@InSightHealth.com.